

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039224

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 35

Primary Registration District No. 3011

Registrar's No. 107

FILED OCT 18 1963

1. PLACE OF DEATH

a. COUNTY **Carroll.**

b. CITY (if outside corporate limits, give TOWNSHIP only)

Carrollton

Length of stay in 1b

3 months.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Missouri** b. COUNTY **Carroll**

c. CITY OR TOWN **Wakenda**

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION **508 N. Monroe.**

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

ADDRESS

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)

First **Mertie** Middle **Lavana** Last **Naught.**

4. DATE OF DEATH

Month **10-** Day **14--** Year **1963**

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

6-19-88

9. AGE (last birthday)

75

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Housework

11. BIRTHPLACE (City and state or country)

Vandalia Missouri.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Warren Wheeler

13b. MOTHER'S MAIDEN NAME

Martha Jane Wheeler

14. NAME OF HUSBAND OR WIFE

William Naught(Dec.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)

No

No

16. SOCIAL SECURITY NO.

17. INFORMANT Address

Mrs Tom Miller(Wakenda Mo.)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Probable Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

Immediate

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **First call Emergency - Patient Dead when I arrived.** to **and last saw him alive on**

Death occurred at **About 4 P** m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

Edith J. Vinyard MD

22b. ADDRESS

Carrollton Mo -

22c. DATE SIGNED

10-15-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

10-16-63

23c. NAME OF CEMETERY OR CREMATORY

Adkins Cemetery.

23d. LOCATION (City, town, or county)

East & South of

(State)

Mo.

24. FUNERAL DIRECTOR

Marshall F. Home Carrollton Mo.

ADDRESS

25. DATE RECD. BY LOCAL REG.

OCT 16 - 63

26. REGISTRAR'S SIGNATURE

Mary Dean

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed P. M. Marshall - SR.

Licensed Embalmer No. 2525

P. O. Address Carrollton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.